UNDERSTANDING FLEXIBLE BENEFITS

Flexible Benefits started when Congress passed Section 125 of the Internal Revenue Code in 1978. Section 125 allows certain qualified expenses, estimated for a given year, to be deducted directly from your paycheck and claimed for reimbursement when used. These deductions are taken before taxes, therefore, reducing your taxable income.

Example: Mary is single with three children and Mary earns $3,000 per month. She pays $125 a month in childcare expenses and $25 a month for prescriptions. The calculations below show how much Mary will save by participating in the Flexible Benefit Plan her company offers.

WITH FLEXIBLE BENEFITS		WITHOUT FLEXIBLE BENEFITS	
$3,000.00	Income	$3,000.00	Income
-150.00	Expenses	-332.00	Federal Tax
$2,850.00	Taxable Income	-90.00	State Tax
-295.00	Federal Tax	-229.50	SocSec/Medicare
-85.55	State Tax	$2,348.50	Net Income
-218.02	SocSec/Medicare	-150.00	Expenses
$2,251.43	Mary's Income	$2,198.50	Mary's Income

****MARY WILL SAVE $52.94 EACH MONTH AND $635.15 A YEAR BY PARTICIPATING****

DEPENDENT CARE REIMBURSEMENT

Dependent Care Reimbursement enables you to deduct childcare (day care) or elder care expenses up to $5,000 a year per family or $2,500 if married filing separate, before taxes. A claim is then filed to receive reimbursement for the expense(s). **Eligible Expenses include** charges for before and after school programs, babysitting, day care, summer camps, and elder care.

The following rules apply:

- You must substantiate the expense with a receipt showing the date(s) of service, amount charged, and the provider's name and federal identification or social security number.
- A dependent must be under age 13 or disabled at any age
- The service(s) must be provided while you and your spouse work, or attend school full-time.
- Expenses cannot exceed the lower income of either spouse.
- If using a day care center, it must be licensed.
- Baby-sitting services provided by a dependent relative under the age 19 are not eligible
- Overnight camps are not eligible

HEALTH CARE REIMBURSEMENT

Health Care Reimbursement enables you to deduct medical, dental, and vision expenses up to the maximum annual amount set by your employer, before taxes. A claim is then filed to receive reimbursements for the expense(s). **Eligible Expenses include** (but are not limited to) charges for medical, dental, or vision office visits, prescription drugs, over-the-counter drugs purchased to treat a medical condition *(Prescription from an Doctor is required), x-rays, labs, orthodontia, teeth cleanings, bridges, crowns, eye exams, glasses, contacts, lasik eye surgery, ambulance and emergency room fees, diabetic supplies, dust-free products, alcohol and drug treatment centers, smoking cessation programs, and weight loss programs for obesity.

The following are some (but not all) items that are not eligible:

- Bleaching/whitening of teeth
- Cosmetic procedures/surgery
- Exercise equipment
- Vitamins

PROCEDURES & SERVICES

- All expenses need to be estimated for the Plan Year. Please be conservative when estimating. Any funds left in the account will be forfeited at the end of the grace period for the Plan Year.

- At the beginning of each new Plan Year, you will be given the opportunity to elect if you would like to participate, dropout, or change your election.

- Your election cannot be changed mid-plan year unless there is a change in your family status that is a qualifying event. The following are qualified events: marriage, divorce, birth or adoption, death, or a change in you or your spouse's employment. All changes must be consistent with your new election choice and must be made within 30 days of the qualifying event. To discuss a specific event, please contact Customer Service.

- As the contribution you elected is deducted from each of your paychecks it is recorded in your Health Care and/or Dependent Care Reimbursement Account(s).

- To receive the funds from these accounts, you must complete a claim form and attach documentation of the type of service provided, amount you are responsible to pay, and date(s) of service(s).

- All claims must be for services incurred during your coverage period of the Plan Year. Incurred is defined as the date in which services are provided. Coverage period is defined as the first of the month in which your first contribution is deducted and the last day of the month in which your last contribution is deducted.

- In the event you terminate employment, the end of the month in which you last contributed to the Plan becomes your termination date. Services performed after your termination date are not eligible for reimbursement.

- Once the claim is reviewed and approved, a reimbursement will be sent directly to your home address or direct deposited to your checking or savings account. You will receive a direct deposit voucher at your home address. Claims received by 5:00 p.m. Eastern Time on Mondays are payable the following Wednesday. Claims received by 5:00 p.m. Eastern Time on Wednesdays are payable the following Friday. Please allow 3-5 business days for direct deposits to be in your account.

- Be sure to notify Customer Service of a change in address by updating it on your claim form or completing and sending in an employee change form. Direct deposit can be updated and sent to Customer Service by attaching a new voided check to your claim form or to an employee change form.

- Access to your account information is available on the Internet at http://www.sheakley.com/flexible_benefits/overview.asp 24 hours, 7 days a week. To access your account, follow the site to the "Participant Center" and click on "MyRSC Login". For security purposes, you must register first by entering your Social Security Number as your "Login ID" to be able to establish your permanent "Login ID" and "Password". The website information is updated daily. You will also receive a statement in the mail 60 days prior to the end of the Plan Year reminding you of any remaining funds in your account and the deadline to submit claims.

- For specific information regarding your plan, the grace period, health care annual limit, plan year, and more, please refer to your Summary Plan Description or contact Customer Service.

CUSTOMER SERVICE

Customer Service representatives are available to assist you from 8:00 a.m. to 5:00p.m. Eastern Time Monday through Friday, except on holidays. Customer Service can assist you with determining if a certain expense is eligible for reimbursement, if a certain change in your family status is considered a qualifying event, and much more.

Sheakley / Flexible Benefits Division
One Sheakley Way/Cincinnati, OH 45246
Phone: (800) 877-6630 or (513) 326-4662
Fax: (513) 326-4661
Email: 125@sheakley.com
www.sheakley.com

ELIGIBLE & NON-ELIGIBLE EXPENSES

To substantiate the expenses you will need to submit documentation that clearly shows the type of service, date of service, and the amount you are responsible to pay, along with a completed claim form. For over-the-counter items, a cash register receipt with the product name listed is required.

The following lists are expenses that will be covered and expenses that will not be covered.

COVERED ITEMS

Acupuncture
*Air Filters
Alcoholism/Drug Abuse treatment
Braille books/magazines
*Breast Reduction/Reconstruction
Car hand controls
Childbirth classes
Chiropractic
Christian Science Practitioners
Coinsurance amounts
Contact Lenses & solutions
Co-payments
Crutches
Deductibles
Dental treatments
Eyeglasses
Fertility treatments
Foreign Country medical expenses
Guide dogs/expenses
Hearing Aids
Hospital co-pays/expenses
Human Guide expenses
*Impotence Treatment
Laboratory fees
Lasik Eye Surgery
*Massage
*Mattresses
*Mileage for Medical Travel
*Nursing Home Care
Office visit co-pays
Optometrist fees
Orthodontia
Orthopedic shoes
Osteopathic expenses
*Over-the-counter items **(see below)**
Prescription medications
PRK/Lasik
Psychologist fees
Radial Keratotomy
Smoking Cessation programs
Sterilization
Sunglasses (prescriptions)
Vision Care
*Weight Loss programs
Wheelchair equipment/expenses

This is not a complete list. If you have any questions regarding a specific type of expense that is not listed, or questions about items that are listed, please contact Sheakley Flexible Benefits Division toll-free at 800-877-6630 or e-mail to 125@sheakley.com.

Items marked with an * are only eligible if they are submitted with a written prescription from a medical doctor (MD) stating they are medically necessary and being used to treat a specific medical condition.

OVER-THE-COUNTER MEDICINES

*****Effective 01/01/2011, the Following Over-The-Counter Medicines Require a Prescription from a Doctor*****

Allergy medicine Sunburn relief and sunscreens
Antacids
Anti-diarrhea medicine
Aspirin
Bactine
Ben Gay or products for muscle or joint pain
Bug bite medications
Calamine lotion
Cold medicine
Cough drops
Cough syrups
Diaper rash ointment
First aid cream
Heartburn medicines
Hemorrhoidal cream
Hydrogen Peroxide
Heartburn/Acid Reflux/Antacids
Laxatives
Liquid adhesive for small cuts
Medicated shampoo
Medicated soap
Lactose Intolerance Medicines
Laxatives
Menstrual Pain Medication
Motion Sickness Medication
Motion sickness pills
Nasal sinus sprays
Pain relievers
Pedialyte
Rubbing alcohol
Sinus medications
Sleeping aids for occasional insomnia
Spermicidal foam
Sunburn relief
Suppositories
Wart Removal Medications
Weight Loss Drugs
Wrist/Ankle/Knee Supports
Vitamins
Visine or other eye products
Yeast infection treatments

This is not a complete list. If you have any questions regarding a specific type of expense that is not listed, or questions about items that are listed, please contact Sheakley Flexible Benefits Division toll-free at 800-877-6630 or e-mail to 125@sheakley.com.

OVER-THE-COUNTER ITEMS

*****The following over the counter items are not considered medicine, therefore a prescription from a doctor is not required*****

Bandages
Blood pressure kit
Carpal tunnel wrist supports
Cold/hot packs for injuries
Condoms
Contact lens solution
Diabetic Insulin
First aid kits
Gauze pads
Incontinence supplies
Nasal strips
Nicotine gum or patches
Ovulation kit
Reading glasses
Denture Adhesive Products
Thermometers

This is not a complete list. If you have any questions regarding a specific type of expense that is not listed, or questions about items that are listed, please contact Sheakley Flexible Benefits Division toll-free at 800-877-6630 or e-mail to 125@sheakley.com.

ITEMS THAT ARE NOT COVERED

*****The following items are not considered to be medically necessary, therefore not reimbursable under the FSA plan.*****

Bleaching of teeth
Cosmetic Item
Cosmetic Surgery
Dietary Supplements
Moisturizers
Tooth Brushes (including electric)
Drugs not approved in the US
Whitening of teeth
Medicated Soaps Shampoos
Toiletries
Mouthwash
Weight Loss Food
Chapstick
Deodorant
Face Creams
Toothpaste

This is not a complete list. If you have any questions regarding a specific type of expense that is not listed, or questions about items that are listed, please contact Sheakley Flexible Benefits Division toll-free at 800-877-6630 or e-mail to 125@sheakley.com.

Deadline for incurring services

In May 2005, the IRS ruled to allow more time for participants to incur expenses each year and reduce the chance for forfeitures. Your employer has elected to modify the flex plan to include this option. Workers who are unable to spend their funds prior to the end of the plan year, now have an extra 2 1/2 months, after plan year-end, to incur eligible expenses before being forced to forfeit unused funds. It is essential to understand that the use-it-or-lose-it rule still exists, but the extension greatly softens the blow by allowing you more time to use your unspent FSA balances. How it works: Let's say you miscalculate and wind up with a leftover FSA balance of $500 on December 31, 2011. Under the new IRS guidelines, you have until March 15, 2012 to incur enough qualified expenses to use your $500 balance. The 90 day grace period deadline will still end March 31st to turn in any expenses you want applied to the 2011 plan year.

Please be advised that claims submitted within the 90 day grace period, which were incurred in the first 2 ½ months following the end of the plan year, will be applied as follows: - Any unused funds from 2011 will be applied first for reimbursement of the claim. - Any 2012 funds will be applied to the claim, if the requested amount exceeds your leftover 2011 balance.

This gives you 14 1/2 months to recover 2011 FSA contributions and provides a much-needed margin for error when figuring out how much to contribute to your FSA each year.

Note: The 2 ½ month extension does not apply to terminated employees, or participants who terminate their coverage during the plan year due to a qualified event.

How Reimbursements Work

1. **Reimbursements are Based on Service, Not Payment:**

   A big misconception is that if you pay for a service, then you are eligible for reimbursement. This is not true. Once a service is performed, regardless if payment has been made, you become eligible for reimbursement. There are pro's and con's to this rule.

   PRO – Once services have been rendered; just send in the bill and Sheakley will send you reimbursement.

   CON – Prepayment for services are ineligible for reimbursement until the service has taken place.

   Please remember with regards to the above, the services must have been incurred while you had coverage. Additionally, the service would need to be for a plan year that is currently active.

2. **Providing the Correct Documentation to Ensure Speedy Reimbursements:**

   Please be sure you are using the correct and most up-to-date claim forms. These are sent to your employer prior to the start of every new plan year, and are available at www.myrsc.com. They can also be emailed or faxed to you, just contact one of our customer service representatives at 1-800-877-6630.

   In addition to filling out your claim form, you need to provide third party documentation (canceled checks, credit card receipts, and credit card or bank statements are not considered proper documentation). Third Party Documentation means documentation from the provider, or an Explanation of Benefits from your insurance. This documentation MUST include three things:

   1. The Date of Service. (Not the date of payment)

   2. The Type of Service. (Service performed)

   3. The Amount you are responsible to pay. (Remember again with this, it does not matter if the service has been paid.)

*** Please note: Sheakley only needs copies of your documentation. **PLEASE DO NOT SEND ORIGINALS** as you should retain them for your records.***

Direct Deposit

This option is a great way to receive your reimbursements quickly by having them deposited directly into your checking or savings account. There are a few things to remember with regards to Direct Deposit.

1. If you currently have Direct Deposit set up, there is no need to set it up again. Your information is carried over to each new plan year. Direct Deposit remains in effect until you send a letter requesting it be turned off. (Please do not send a copy of a voided check every time you send a claim.)

2. In order to have Direct Deposit set up, you need to send a COPY of a voided check, or a letter from your bank, with your first clam form of the year.

***Please note: Direct Deposit CAN NOT BE SET UP if you send a deposit slip, or you hand write your information. We MUST receive a copy of a voided check, or a letter from your bank.**

Dependent Care
(What it is and How it Works)

Dependent Care allows participants to set aside pre-tax funds from their paycheck to pay for daycare and eldercare services. There are a few misconceptions on how this plan works, and how a participant is reimbursed for these expenses.

The Dependent Care Plan is for daycare expenses for children and certain care expenses for disabled dependents and elderly parents. (We recommend you consult a tax consultant regarding your eligibility for claiming disabled dependents or elderly parents.)

1. **Day Care Expenses**. There are specific rules and regulations when it comes to reimbursement for day care services. Day care expenses are covered until the child reaches the age of 13. Once the child reaches the age of 13, they are no longer eligible and the participant MUST cease participating in this plan.

2. **Tuitions.** Tuition for **Pre-School IS COVERED**, as the government does not consider Pre-School to be educational. Since this plan is designed for care, and not education, once a child enters Kindergarten the only expenses that are reimbursable are before and after school programs that the child attends so that both parents may work, or attend school.

3. **Babysitters.** These providers generally care for children of the employee in the employee's home and are not usually regulated. They can be grandparents or other relatives, friends, or neighbors. However, payments are not reimbursable if the babysitter is the employee's child or stepchild who is under age 19, or if the babysitter is a dependent for whom the employee or spouse can claim an exemption on Form 1040. **The social security number of the provider is required for reimbursement.**

4. **Camps.**
   Summer Day-camp: Yes, to the extent attributable to care of dependent regardless of whether the program includes instruction for sports or other extracurricular activities. The primary purpose of the expense for summer day-camp should be custodial in nature and not educational.

   Over-Night camp: Since the Dependent Care plan was designed to assist in care while parents are at work, over-night camps are **NOT COVERED** under this plan.

5. **Custodial or elder care expense.** Only if (a) such expenses are not attributable to medical services; and (b) the qualifying individual (other than a dependent under age 13) still spends at least eight hours each day in the employee's household.

6. **Food expenses.** No, if charged separately from dependent care expense. May be eligible if inseparably part of dependent care charge. In other words, if the food is included in the price of the dependent care, then It can be covered if the cost of the food is separate from the cost of the dependent care, then it will not be covered under this plan.

How Am I Reimbursed for Dependent Care Expenses?

As with the Healthcare plan, reimbursements are performed based on service, and NOT PAYMENT. In other words, a plan may not reimburse a claim in August for the participant's advance payment of a child care center's bill for care to be provided in September. Although the participant paid the child care bill in August, the expense is not "incurred" until the services (child care) are actually provided. The plan may not reimburse the participant for the expense until October, after all of the September services have been provided.

Good News Regarding Payment*

With Sheakley's new Dependent Care claim form, the monthly expense can be broken down on a weekly basis, this means that if you paid $500.00 for the month of August, with the new claim form, you can break it up into weekly amounts so that at the end of each week, a portion of your claim is substantiated and if there are funds in your account, you will be reimbursed. Please be sure you use the most up-to-date claim form.

HEALTH CARE WORKSHEET

This worksheet will help you estimate your family's annual expenses for the new Plan Year. Please remember to deduct what your insurance will pay on each item. Not all covered expenses are listed: this is a list of some of the most common expenses submitted. If you are not sure if an expense is eligible, please contact Customer Service via email at 125@sheakley.com.

Medical Expenses	**Current year's expenses**	**Estimate for next year**
Deductible	$_____	$_____
Co-payments: Office	$_____	$_____
Prescriptions	$_____	$_____
*Over-the-counter items	$_____	$_____
(*For medical treatment only)		
Chiropractors	$_____	$_____
Hospital Care	$_____	$_____
Physical Therapy	$_____	$_____
Routine Physical	$_____	$_____
Well Baby Care	$_____	$_____
Psychiatric Care	$_____	$_____
Other	$_____	$_____
Vision Expenses		
Eye Glasses	$_____	$_____
Eye Exams	$_____	$_____
Contact Lens	$_____	$_____
Lasik/Vision Correction	$_____	$_____
Dental Expenses		
Dental Exams	$_____	$_____
Extractions	$_____	$_____
Fillings	$_____	$_____
Crowns	$_____	$_____
Bridges	$_____	$_____
Orthodontics	$_____	$_____
X-rays	$_____	$_____
Other	$_____	$_____

Total Estimated Expenses $_____

Number of paychecks in the plan year _____

Divide to show per paycheck pre-tax deduction: $_____

Check your numbers carefully and remember to be conservative. Any funds left in the account are forfeited. Only estimate expenses you know you or your dependents will have completed.

DEPENDENT CARE WORKSHEET

This worksheet will help you estimate your family's annual expenses for the new Plan Year. If you are not sure if an expense is eligible, please contact Customer Service via email at 125@sheakley.com.

1.	Day Care Expenses	$_____/week x 52 weeks =	$_____
2.	Estimated time away from the day care or sitter (vacations or holidays)	$_____/week x # weeks =	$_____
3.	Subtotal	#1 minus #2 =	$_____

Does your child start school this year? If so calculate only the full months that he/she is not in school and partial daycare for the remainder of the Plan Year.

4.	Estimated change in Expenses (day care Increases or decreases In the amount)		$_____
5.	Estimated Yearly Day Care Total	#3 plus/minus #4 =	$_____
		Divided by number of paycheck dates =	$_____

REMEMBER TO BE CONSERVATIVE: any funds left in this account will be forfeited.

Sheakley
It's done.

ENROLLMENT FORM

SECTION 1: Participant Data

Please legibly complete the following information to set up your account.

Employee Name (First/Last)			Social Security #
Home Address	City	State	Zip Code
Hire Date	Birth Date	Email Address	
Employer: City of Torrance	(Division, If applicable)		

SECTION 2: Elections

Enter the amount you wish to contribute per pay period, the number of paychecks you will receive during the entire plan year, multiply the per pay by the number of paychecks for the annual election, and enter the first paycheck date in which a deduction will be withheld.

Plan Year:01/01/2012-12/31/2012	Per Pay Contribution	# of Paychecks Remaining	Annual Election	Effective Paycheck Date
Health Care Reimbursement (Annual Limit $6,000.00)	$	#	$	
Dependent Care Reimbursement (Annual Limit $5,000.00 per household or $2,500.00 if married filing separate)	**$**	#	**$**	

SECTION 3: Pre-Taxed Premiums

I understand my insurance premiums, offered by my employer only, will be deducted on a pre-tax basis unless I note otherwise, in writing, to my Human Resources Office.

SECTION 4: Plan Information

Please read the following information regarding this enrollment. If you do not wish to participate in the Flexible Benefit Accounts, sign the declination line. If you wish to enroll into the Flexible Benefit Plan, sign the participation line.

I wish to participate and deposit to the Flexible Spending Account (FSA) as shown above. I understand that my election may not be terminated or changed unless I have a qualified life event as outlined by the IRS. I understand that all claims must be for services provided (not paid) during my coverage period. I further understand that the IRS requires a forfeiture of any remaining balance in my account, as of the last day of the grace period in which I am allowed to submit claims. I understand that upon termination of my coverage (due to a qualified life event or termination of employment) I cannot continue to incur additional expenses; I may only submit claims for services performed prior to my termination date. Upon termination of my Healthcare Reimbursement Account, I may be able to elect COBRA to continue my coverage. In order to receive reimbursement from this account, I must complete and sign a claim form and attach all necessary documentation for myself or my dependents. I understand the plan provisions have been outlined in the Summary Plan Description available to me from my employer.

In addition, I understand that if I have a Health Savings Account (HSA), I am not eligible to participate in the FSA plan.

PARTICIPATION SIGNATURE: _____ DATE:_____

WAIVER: **At this time I wish to waive participation in the Flexible Benefit Account.**

DECLINATION SIGNATURE: _____ DATE:_____

All Enrollment forms must be submitted to your HR Department for processing.

EMPLOYER SIGNATURE: _____ DATE:_____

To: City of Torrance Flexible Benefits Participants

Below are instructions to log into the new online Flexible Benefits Plan account inquiry. This new online feature is a password protected web site, where you can keep up with various benefit news, including your year-to-date claims and payments. To log in to *my*RSC for the first time, follow the steps below:

1.Go to http://www.sheakley.com/Flexible_Benefits/Resource_Center.asp.
2.Click on MyRSC Login.
3.Click on Register.
4.Enter your SSN (no dashes or spaces) in the Login ID field and click continue
5.Enter 25950569 in the Employer Code field.
6.Enter a login ID of your choice that is at least 6 but not more than 100 characters in length. Note: Since Social Security Numbers are no longer used as the login ID, the login ID you create may not be 9 characters in length.
7.Select an existing e-mail address or enter a new one to be used to e-mail forgotten passwords.
8.Enter a secret question or use a predefined secret question to prompt your memory of your password.
9.Enter the answer to the secret question.
11.Click **SUBMIT**.
11.Click the continue link.
12.Enter a password in the Password field.
13.Re-enter the password in the Confirm Password field.
14.You are now logged into *MyRSC*.

If you have any questions, please call our Customer Service Department at 800-877-6630.

513.771.2277 Phone
800.877.2053 Phone
One Sheakley Way
Cincinnati, Ohio 45246
Sheakley.com

EMPLOYEE PERSONAL DATA CHANGE FORM

Please complete and sign this form. Give to your Human Resources Department who will forward to Sheakley via fax to (513) 326-4661.

_____ _____ - _____ - _____
Employee Name Social Security #

_____ _____/_____/_____
Company Name Effective Date of change

CHANGE IN NAME

_____ _____
Old Name New Name

CHANGE IN ADDRESS

_____ _____
New Street Address/P.O. Box New City

_____
New State & Zip Code

SIGNATURE REQUIRED

_____ _____
Signature **Date**